

petty officer third class was reminded—the hard way—of this age-old law of physics when a 500-pound maintenance platform crashed down on her left arm. How could this happen in the modern Navy?

The story contains the usual recipe for disaster: having a lax attitude, using shortcuts, violating precautions, and not reading maintenance instruction manuals (MIMs). The AS3 had been assigned to the support-equipment, corrosion-control workcenter for four months before the incident. She took pride in her profession and relished the chance to convert old, decrepit support equipment into shiny, almost-new gear.

The mishap occurred when the AS3 removed a hydraulic hose from the hydraulic ram on a B-4A maintenance stand before she inserted the safety pins. This missed procedure clearly is mentioned in the MIM. With the hose removed, hydraulic pressure was lost, and the platform came crashing down. Her arm was trapped between the scissors assembly and the

platform base. She screamed for help, and four coworkers came to her rescue, lifting the platform off her injured arm.

The platform fell only 10 inches, but the AS3 suffered damaged nerves and numbness in her hand. An operation repaired the nerves in her arm. It could have been worse; she's lucky her arm wasn't severed.

The B-4A maintenance stand was the fourth one she had worked on in the last month. The task had become so routine she decided to start the job alone and without using the MIMs—her first mistake. After climbing onto the stand, she jacked up the platform to inspect the scissors. After she had raised the platform, she didn't install the safety pins—mistake two. The third and final error was removing the hydraulic hose from a pressurized hydraulic system.

If she had had a co-worker with her or had taken time to read and follow the MIMs, this mishap never might not have happened. If she had followed all precautions, installed the safety pins, or relieved all



Before you stick your head or hands into the scissors area, make sure the stand is safe.





The safety pins must be fully inserted to prevent a collapse.

hydraulic pressure, the platform would have remained in place, and the mishap would not have occurred. The AS3 learned a valuable and painful lesson from this incident: Cutting corners never is right and does not always save time.

It has been a long time since the mishap, but the AS3 still has numbness in her hand. Five minutes spent reading the maintenance manual would have saved her a lot of pain and a recurring medical problem.

Petty Officer Farley is the safety petty officer at AIMD Det Rota, Spain.

For more info...

NavAir 19-15-7, chapter 5-2, states, "Lower platform to its lower position, drain hydraulic fluid from pump, ram, and hydraulic line before proceeding with the following disassembly instructions."

This safety pin is in place, and the flange rests squarely on the rail.



Class B Mishaps 02/07/2002 to 05/20/2002

Aircraft Command Date

TAV-8B **VMAT-203** 02/09/2002 Forward canopy glass shattered in flight.

SH-60F HS-5 02/10/2002 Sonar dome departed aircraft during night coupled hover.

FA-18C VFA-106 02/25/2002 Centerline drop-tank departed aircraft in flight.

C-2A VRC-40 03/12/2002 Outboard vertical stab separated from aircraft in flight.

FA-18C VMFA-323 03/18/2002 Aircraft fire on takeoff.

FA-18D VMFA(AW)-533 04/03/2002 NAVFLIR departed aircraft during 2 v 2 all-weather intercept.

VF-2 F-14D 04/09/2002 Post-flight inspection revealed starboard engine had ingested a screw, resulting in engine FOD.

F-14D VF-31 04/22/2002 IFR basket separated from KC-135 tanker during in-flight refueling, damaging starboard engine.

FA-18C **VMFA-212** 05/05/2002 During IFR, aircraft lost its probe's tip, causing starboard engine FOD.







